STATE OF ARKANSAS

Department of Finance and Administration

Employee Benefits Division

www.ARBenefits.org

This form must be returned to your Health Insurance Representative; not EBD.

Change Form

Status, Name and Address

1. Employee Information: (please print)

Last Name	First Name		MI	❐ Married ❐ Single
Home Address	City	State	Zip Code	
SSN#	Date of Birth:	Home #:	Work #:	
If you would like benefit information sent to you by email, please print your email address:				
Primary Care Physician:	PCP #	Current patient?		

2. Change in Dependent Status (complete this portion if making any changes in dependent status):***

LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❐ Add ❐ Delete	
Primary Care Physician:	PCP #	Full time student?**	
LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❐ Add ❐ Delete	
Primary Care Physician:	PCP #	Full time student?**	
LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❐ Add ❐ Delete	
Primary Care Physician:	PCP #	Full time student?**	
LAST NAME	FIRST NAME	MI	GENDER
Social Security #	Date of Birth	❐ Add ❐ Delete	
Primary Care Physician:	PCP #	Full time student?**	

*** Please submit guardianship, court-ordered insurance responsibility or adoption papers on dependents that apply.**
**** For dependents 19 and over only. Please submit proof of student status.**
***** Social Security # is not required to add coverage for a newborn.**

3. Change In Coverage (complete this portion if making any of the following changes):

Change in Status:		Reason for Change:
❐ Employee Only	❐ Add Dependent	❐ Birth - Date: ____________
❐ Employee & Spouse	❐ Delete Dependent	❐ Death - Date: ____________
❐ Employee & Children	❐ Name	❐ Divorce - Date: ____________
❐ Family	❐ Address	❐ Marriage* - Date: ____________
❐ Cancel Coverage		❐ Other: ______________________________

*** Please attach Marriage License; Maiden Name if applicable**

4. To Be Completed By Agency/School District:	
Agency/School Name:	Agency/School District Number:
Effective Date of Change:	Employee #:
If employee is transferring from another agency/district, please provide name:	

I have reviewed this Change Form and believe that the requested action is in accordance with the EBD Benefits Administration Manual.

Health Insurance Representative/ School Business Official Signature: _____

Print Name: _____

5. Please Read Before Signing:

I understand and agree that: (1) The information provided on this application is accurate and complete. (2) Any omissions or incorrect statements made by myself or anyone on this application may invalidate my and/or my dependents' coverage. (3) Coverage will become effective only on the date specified by the Insurer after the application has been approved by the Insurer and after the first full premium has been paid. (4) My signature authorizes Coordination of Benefits under this coverage with other insurance I have that is subject to coordination. (5) I hereby authorize deductions from my earnings of any required insurance contribution. (6) That my eligibility and/or the eligibility of any covered dependents may be audited by EBD, or other designated party, at any time. (7) By signing this enrollment form, I hereby certify that all the information provided is true and correct.

AUTHORIZATION TO OBTAIN MEDICAL INFORMATION: On behalf of myself and anyone enrolled on or added to this application, I authorize any health care professional or entity to give the health plan/insurer or any of their designees, any and all records or information pertaining to medical history or services rendered to the health plan/insurer, for any administrative purpose, including evaluation of an application or a claim, and for any analytical or research purpose, including evaluation of an application or a claim. I also authorize on behalf of health plan/insurer, the use of a Social Security Number for purpose of identification. A photocopy of this authorization will be as valid as the original.

Any person who knowingly obtains health coverage when not eligible for coverage, presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines, confinement in prison, repayment for plan losses/claims, or loss of health coverage for life.

I understand that if I refuse to apply now and I apply for coverage at a later date, my request may be deferred until open enrollment.

Employee's Signature: _____ **Date:** _____

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